The Whitaker School

At John Umstead Hospital

L Street Butner, NC 27509-1626

Michael Easley
Governor

Michael Lancaster/Leza Wainwright
Division Directors

Jeff Lenker
Director

Phone: (919) 575-7927 General Fax: (919)575-7895 Confidential Fax: (919)575-7489

Procedures for Admission to Whitaker School

(1) Brief referral information is taken over the phone to identify obvious factors that would rule out an admission.

(2) An application packet is completed and forwarded to the LME in which the client resides. (It is important to note that the packet must contain psychological testing establishing IQ within the last two years. The Visiting Resource is a **community-based placement** at which the student spends **two weekends a month away from Whitaker**. This resource **must be in place** before an applicant can be considered for admission to Whitaker School.)

(3) Once the LME has approved the request for admission, the application packet is forwarded to Whitaker School.

(4) The Whitaker School Admissions Committee reviews the application to determine if the applicant is generally appropriate for the program.

(5) If there are no beds available, the applicant is put in a **waiting pool** of other applicants. Applicants are not admitted in any sequential order. It is critical that Whitaker receive updates from the applicant's community if the applicant is awaiting admission. Current information on the applicant's status helps the admissions process and is a factor in deciding which applicant is admitted.

(6) When a bed becomes available, the Admissions Committee selects an applicant whose characteristics (ie. sex, diagnosis, acuity, type of behavior, gang affiliation, etc.) best fits the available slot is selected for possible admission.

(7) Once an applicant is identified, Whitaker School staff arrange a face-to-face interview with the applicant to make the final determination of whether the applicant is to be admitted to the available bed. **No bed is guaranteed prior to this interview.**

(8) Logistics for the admission will be arranged by a Whitaker School Social Worker.

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Dear Stakeholder,

In order for Whitaker School to consider a referral, screening and prioritization of the applicant must take place at the LME/AMH level. The Secure Residential Packet attached to this letter must be completed and submitted to the local Community Collaborative for review.

Referral packets should be completed by the Community Support Provider along with the Child and Family Teams and reviewed by the Community Collaborative. A decision should be made with regards to the appropriateness of the referral and the child should be prioritized in the context of other referrals from the LME. The Chairperson of the Collaborative and the LME Director (or the Director's designee) **must** sign in the appropriate space at the bottom of the page for the referral to be considered. The completed referral packet should then be sent directly to Whitaker School.

The referral authorization below **must** be completed and **mandatory** information provided, for an application to be processed. In order for a child to remain prioritized on the list, bi-monthly updates from the LME **must** be sent to Whitaker School. The form for this update is the last page of this packet. Updates should be faxed to 919-575-7489.

If you have questions, please contact Whitaker School at 919-575-7927 (dial 0 for the operator) with any questions that you have and you will be connected with someone who can help.

Thank you,
Ray Newnam, Ph.D.
Senior Psychologist, Whitaker School
Ray.Newnam@ncmail.net

Authorization of Referral

Name of
LME/AP:_____

Approved by Director or Designee:_____
DATE

This referral has been reviewed and approved by:

_____
Community Collaborative Chairperson/Child and Family Coordinator/LME Director Date

Our Program has _____ number of children referred. This child is prioritized at number ____ on the list (#1=top priority).

1. **IDENTIFYING INFORMATION**

Name:_____

Date of Birth:__/__/____ Sex: ☐ Male ☐ Female Height ____ Weight_____

County of Residence:_____

Referring Mental Health Area Program:_____

Referring Case Support Provider:_____

Address:_____

Phone:_____

D.S.S. Worker:_____

Address _____

Phone/Fax _____

D.J.J. Worker: _____

Address:_____

Phone/Fax:_____

Funding Source(s): Insurance/Medicaid #'s for Treatment Expenses:_____

_____

Allowance/Personal Effects Provider:_____

_____

2. **CURRENT STATUS**

Legal Guardian:_____

Address:_____

_____

Phone:_____

Applicant's Current Placement:_____

Address:_____

_____

Legal Status /Juvenile Court Involvement:_____

Current Educational Placement/Exceptionality/Grade Level:_____

List and describe interventions/placements previously tried and which aspects were successful/unsuccessful (include out-patient treatment, residential, hospitalization, etc.)

If there are additional placements, please attach.

Treatment Intervention/Placement	**Dates**	**Applicant Response**

3. **DIAGNOSTIC INFORMATION**

DSM-IV Diagnoses/Date of Diagnosis: _____

Previous DSM-IV Diagnoses of Concern:

IQ (FSIQ, Verbal Comprehension Index, Processing Speed, Working Memory, and Perceptual Reasoning Index)/Level of Functioning Assessments/Dates of Testing:

Note: If Verbal Comprehension Index is below 75 or Full Scale is below 70 it would be unlikely that the applicant would benefit from the program. A referral to the STARS program at Murdock is recommended.

Substance Use /Abuse History: _____

Sexual Offense/Abuse History: _____

Gang Affiliation if any: _____

Primary Symptoms/Behaviors (check all that apply)

	Yes	No	Unknown	If yes, describe
Psychotic	☐	☐	☐	
Assaultive	☐	☐	☐	
Destructive	☐	☐	☐	
Suicidal or Self-Destructive	☐	☐	☐	
Runaway Tendencies	☐	☐	☐	
Sexual Acting Out	☐	☐	☐	
Substance Abuse	☐	☐	☐	
Other	☐	☐	☐	

Strengths/Assets:_____

_____

_____

_____

Medical Problems

Current Medications (Dosage)

4. ECOLOGICAL INFORMATION

*****NOTE: EACH STUDENT MUST HAVE A VISITING RESOURCE FOR MANDATORY, TWICE-MONTHLY VISITS IN THE COMMUNITY IN A SAFE AND SUPERVISED ENVIRONMENT FOR SUCCESSFUL REINTEGRATION INTO THE COMMUNITY. STEP DOWN PLACEMENTS MUST BE INDICATED AND APPROPRIATE.*****

Plan/Identification/Description of Visiting Resource:

Plans for transportation to and from Visiting Resource:

Discharge Plan - Whitaker School prepares students to live in less restrictive environments on discharge. However, the problems of our students are more severe than most. They continue to need intense services (although not in a locked facility) after they leave Whitaker. Please be specific and detailed about the child's program at discharge:

Parental/Family Involvement:

Does this child have a family permanently committed to him/her? Yes ☐ No ☐

If "yes", how will this child's family be involved in treatment during placement?

_____

_____

If "no", who will represent this child in the role of surrogate parent?

_____

_____

Behaviors or conditions that make continued placement in the home community difficult.

_____

_____

_____

TREATMENT ISSUES

Why are you referring?_____

_____

_____

List questions that need to be answered for the child to be successfully maintained in the community?_____

_____

_____

What services will the area program provide while the applicant is in Placement?_____

_____

_____

Signature:_____ **Date:**_____

Person Making Referral

Signature:_____ **Date:**_____

Collaborative Chairperson/Child & Family Coordinator

Additional Information (Please attach information behind this page)

For the referral packet to be placed on the waiting list, all starred items must be provided in the packet. The packet will remain on a prospective list until this information is provided. *NOTE: Developmentally disabled and/or mentally retarded students should be referred to the STARS Program at Murdoch Center. (Phone Number: 919-575-1070)*

Psycho-educational Testing: (**NOTE**: **To be considered, a psychological with IQ scores that are within 24 months of the referral is mandatory. The entire report must be sent, not just the scores)**

*_____ Psychosocial Assessments

*_____ Psychological Testing Including IQ Testing (within the last 2 years)

*_____ Admissions Assessment Psychiatric Hospitals or Mental Health Centers

*_____ A detailed Life Chart or a thorough Developmental/Social History

*_____ Discharge Summaries from Prior Treatment Facilities (if applicable)

*_____ Achievement testing (most recent and/or within the last 3 years)

* _____ School Transcripts (most recent)

*_____ Report cards (most recent and previous report cards for the entire current school year)

*_____Standardized testing (End of Grade [EOG 5-8] and End of Course [EOC 9-12] tests, Computer skills, Reading/Math competencies)

*_____Exceptional Children's Forms to include **all DEC forms** (DEC 1-7 and a current IEP(DEC 4) that indicates BED, L/D, OHI, other)* **Please note that if a child has been identified as an Exceptional Child (EC), legally s/he should have a current IEP.**

***_____** Vision and Hearing Screenings (Recent)

*_____ Current Physical and Immunization Records

*_____ Referral packet information sheets.

*_____ Copy of social security card.

*_____ Copy of birth certificate. (if available)

*_____ Consent to Exchange Information Form

_____ Older report cards from previous school years.

_____ Older psychological testing.

_____ Psychiatric Assessment (mandatory if available)

_____ Personality Assessments (if available)

_____ Discharge Summaries from Psychiatric Hospitalizations (if applicable)

_____ Neurological Testing (if applicable)

_____ Speech/Language Evaluation (if applicable is mandatory)

_____ Most Recent LME Service Plan which includes: Goals, Strengths, and Weaknesses.

_____ DSS Reports (if applicable)

_____ Juvenile Court Reports (if applicable)

_____ Staffing Notes from the Collaborative Meeting

_____ Other_____

_____ Other_____

North Carolina Department of Health and Human Services
Division of MH/DD/SAS
Child and Family Services Section
SECURE CARE REFERRAL UPDATE SHEET

*****(THIS SHEET SHOULD BE FILLED OUT AT LEAST BI-MONTHLY AND FAXED TO 919-575-7489)*****

Client's Name: _____ Date of Approval: _____

Area Program: _____ Date: _____

Check appropriate box for any new or additional information completed since the last update.

- ☐ IEP
- ☐ DEC Forms
- ☐ Treatment Plan
- ☐ Therapy
- ☐ Medication
- ☐ Psychological Evaluation
- ☐ Medicaid
- ☐ Hospitalization
- ☐ Visiting Resource/Step Down
- ☐ Other

Please attach a copy of all new or additional information.

Describe any significant life events and/or changes to his/her living situation since the last update.

_____
_____
_____

Describe any contact with the legal system; courts; and/or police since the last update?

_____
_____
_____

Describe any aggression, physical violence towards others, and/or self-injurious behavior since the last update.

_____
_____
_____

Outline changes in services received since last update.

_____
_____
_____

Priority _____

_____ _____
Community Support Signature Date